VALUE IN HEALTH CARE

An Address By

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NOTE: This text was the basis of the Administrator's oral remarks and should be used with that understanding

It was clearly a sign of Mike Bromberg's foresight to schedule this year's annual meeting here in New Orleans.

After all, the theme of the meeting is "Election 1988, the Politics of Health Care." And here we are, in the heart of the South, just nine days after Super Tuesday, which will help determine who will grapple with the future of health care in America.

I appreciate not only Mike Bromberg's timing, but also his interest in hearing what this Southerner can add to the debate from my perspective as administrator of the nation's Medicare program.

As Shakespeare wrote, "What is past is prologue." Some of our experiences with Medicare over the past eight years, our successes and our failures, can teach us a good deal about the future.

I believe the next Administration will be judged on how well it responds to THREE key forces now driving health care policy.

These three forces are:

the continuing need to contain health-care cost inflation;

the growing need for a more decentralized and competitive health care system to correct the inefficiencies caused by micromanagement; AND

the evolving need to find better ways of measuring and enhancing quality care.

The issues of of quality and cost in health care services are as tightly intertwined as fibers of fine silk. By virtue of size, Medicare must play a considerable role in shaping the debate over those issues.

Today, I would like to review what we in the Medicare program have learned in dealing with cost constraints, competition, and quality assurance.

But more importantly, I hope to show how we can draw these forces together under the concept of "value" in health care.

As Medicare enters its third decade, it is destined, I believe, to focus on the need to purchase value: the optimal mix of quality and reasonable cost. To use Walter McClure's phrase, we need to find ways not so much to "buy cheap" as to "buy right."

Let me begin our discussion today by looking at the lessons we have learned from our efforts at cost containment through the Prospective Hospital Payment System.

I. COST CONTAINMENT

We now have data on three years of hospital performance under PPS. Hospitals in general did quite well financially during the first two years. Medicare profits on average were about 14 percent for both years.

These profits reflected the success of PPS in encouraging hospitals to reduce lengths of stay and encourage care in less costly settings. But high profits were also due to the fact that rates were set too high from the start.

This led some to suggest that we recoup what they termed "excessive" profits. We at HCFA believed, however, that the prudent approach was to give hospitals smaller annual updates.

As a result, Medicare profits were reduced in the third year of PPS to almost 9 percent on average.

But there was another factor beside rate restraint which contributed to the narrowing of profit margins.

Costs per case increased at about 10 percent in each of the first three years of PPS. And there has been no shortage of reasons advanced for it.

Falling admissions have forced hospital costs to be spread over fewer cases. There are other factors as well, including the costs of new technology, and a hospital population that is more severely ill.

As a result, ProPAC has gone so far as to project that profits could turn to losses this year.

We too have found that the rising costs per case could indeed result in losses.

There continue to be two explanations for this rapid rise in hospital costs:

That we have not squeezed tightly enough; OR

That we have given hospitals an almost impossible task: to control physician decision making.

In the coming years, the challenge of cost constraint will continue unabated, but the focus will have to shift from hospital to physician payment reform.

The numbers bear this out:

PPS succeeded in slowing annual growth in Part A expenditures from 16 percent to 3 percent in four short years.

By contrast, Part B expenditures, after a dip, are now growing at a rate higher than four years ago.

At a Ways and Means Committee hearing on this subject last fall, I emphasized that Part B is driven largely by the burgeoning utilization of Part B services.

As we look for ways to constrain Part B growth, using incentive payment systems like PPS for doctors will be difficult. And, since increasing utilization is the major component of this growth, price-only mechanisms like RVS fee schedules will not be sufficient.

The best cost-control mechanism for physician services is a

competitive system, one that puts patients through their own choosing under the care of physicians who utilize services appropriately.

The current Medicare Participating Physician Program is the first step toward such a system.

President Reagan's budget proposal this year also calls for demonstration projects to establish preferred provider program under Medicare.

We propose to select a sub-set of doctors -- the careful and appropriate practitioners of quality medicine -- and then steer a volume of patients to them using economic incentives, such as lower beneficiary copayments.

Both volume and price limits are necessary if total costs are to be reduced. Under the Participating Physician Program, there are relatively modest utilization controls. A preferred provider network would add more of them.

II. COMPETITION

In the long term, however, there is a better way of dealing with these problems -- the Private Health Plan Option under Medicare.

The Private Health Plan Option give Medicare beneficiaries the right to choose to enroll in certain selected HMOs or CMPs as an alternative to fee-for-service Medicare.

The need for the PHPO and other programs which promote competition and choice is so urgent that I consider it the second of three major forces challenging the future of health-care.

Let me make my case by quoting, not a medical economist, or a budget analyst, but one of our Founding Fathers, James Madison.

In the 62nd Federalist Paper, Madison wrote:

> It will be of little avail to the people that the laws are made by men of their own choice if the laws are so voluminous that they cannot be read, or so incoherent that they cannot be understood; if they be repealed or revised before they are promulgated, or undergo such incessant changes that no man, who knows what the law is today, can guess what it will be tomorrow."

Mr. Madison must have had premonitions of Medicare when he wrote that!

Medicare today is so tightly micromanaged by the Congress, so centralized in Washington, that is difficult for anyone to understand,let alone direct.

Last year's massive Omnibus Budget Reconciliation Act, or OBRA'87, contains literally thousands of lines of fine print affecting the Medicare program. A draft implementation plan for OBRA '87 prepared by the staff of HCFA is 45 pages of fine print.

Another HCFA document, on the status of reports due to Congress, contains another 24 pages. This report details the countless documents that Congress requires us to prepare to assist their analysis of the Medicare program.

How anyone can read them, let alone digest them and use them to formulate a coherent public policy, is another question entirely.

Under our uniquely American system of separation of powers with checks and balances, I believe it is much better to rely on a decentralized system and private health plans.

Under a 1982 law change, we now have Medicare risk contracts available as a choice for more than one-half of our 31 million beneficiaries.

And about one million have so chosen -- to enroll in one of 158 plans in 34 states.

We also seek to launch a series of demonstrations of another type of capitated plan -- based on pre-formed groups of Medicare beneficiaries, such as the retired enrollees in an employer or union operated health plan.

They would take part in a Medicare Insured Group demonstration. We recently signed an agreement with the Amalgamated Life Insurance Company to develop such a demonstration.

III. QUALITY ASSURANCE

The PHPO is widely views as a means to control government expenditures and to create incentives for efficiency -- and appropriately so. But PHPO is more. PHPO establishes an appropriate framework for assuring, and promoting, quality of care.

Comprehensive care organizations are better suited to assure continuity of care. Through them, we can keep people well, not just cure the ill.

PPS, by contrast, encourages fragmentation. Payment is per admission, creating incentives for early discharge, but no incentive to avoid future admissions through better management of outpatient care.

This problem could be aggravated if Medicare subsequently adds incentive payment systems for Part B services.

Yet if we are to move toward a system that provides more choice, we must also move toward a system that provides more information to consumers on the best choice to make.

Concerns about quality are also fueled by the continuing pressure on the Federal budget, together with the aging of America.

Thus, the twin forces of cost constraint and competition converge on the third force challenging the future of health care: the evolving need for better methods to measure and disseminate information on quality. In this effort, our goal should be quality promotion, not just quality assurance.

A. Mortality Information

By nominating me to be the Administrator of HCFA, President Reagan in essence put me in charge of the Nation's largest health-care quality assurance program. And "quality is our most

important product."

Just before I took office, Medicare for the first time had released information on the mortality rates at the Nation's acute-care hospitals.

We learned from that experience that the hospital and medical communities needed to play a much larger role in any such future efforts. And more needed to be done to communicate how such information should be interpreted and used.

That is why in December 1986 HCFA convened a quality of care symposium which included professionals from consumer groups, providers and academia.

We subsequently had technical consultations with nationally recognized experts in health and statistics. We spoke with major health care and consumer organizations, as well as with the public.

Once we had decided on our plans, we went to great lengths to be clear. Workshops were held in early December at which the news media and various groups, including the FAHS, are invited.

Then, on December 17, HCFA released its information on mortality rates for Medicare patients at nearly 6,000 hospitals nationwide that treated Medicare beneficiaries in 1986.

The seven volumes contained figures reflecting the mortality rate at each hospital for Medicare patients overall, as well as the rates for patients in each of 16 diagnostic categories, including cancer, kidney disease and stroke.

Each hospital's actual mortality rates were also compared with HCFA's calculation of what could have been expected for the hospital, given the mix of patients it treated.

Hospitals were given an opportunity to present written comments on the statistics, and these comments were published along with the numbers. We took great pains to explain the strengths and limitations of this information. We especially focused on the fact that this is a screening tool.

We decided to release this information not because it was required, but because it is an important contribution to the existing body of knowledge about health care.

The idea is to stimulate further work on methods for quality measurement. The advice we received from all parties was very helpful in helping us to shape a mortality information release that did just that: informed, rather than inflamed.

Now, we are working to move from focusing solely on hospital

quality, to including that of other providers.

Our release of hospital mortality information is one step along a longer but essential road that I am convinced will lead us to be much better able to define and ensure quality in health care.

B. Effectiveness

Yet if we are to make progress in meeting the future challenge posed by quality assurance, we have to be certain that it is done with a realistic eye on the current fiscal climate.

We have a real contrast between the conventional wisdom and reality in health care. For example, the conventional view is that there have been major "cuts" in the Medicare program in recent years. In fact, Medicare has grown more rapidly than has defense in the period 1981 through 1987.

Further, there is the view that the American people value health so highly that they will pay any price, bear any burden, to have the finest in health care. The reality is much more complex than such sloganeering.

We need to question what has been a fundamental premise of the American health care system: "More is better." More is not

necessarily better.

We know that much of the increase in utilization is good and to be applauded -- it is doctors doing good for their patients. But we also know that some of this increase is unnecessary.

We need seriously to examine practice patterns and to reach consensus about appropriate patterns.

All these factors make it clear why we have resolved to explore steps to promote more effective treatment. Unlike quality assurance efforts, which focus primarily on benefit to the patient, effectiveness relates to value -- the combination of quality and cost.

We want to assure that patients receive the maximum benefit in improved health for Medicare dollars.

Unlike cost-benefit analysis, effectiveness does not address the question whether a given patient is "worth" the expenditure. Nor do we want to advance effectiveness as a means for denying payment, or rigidly to dictate the practice of medicine.

A sounder approach would be to give physicians better

information about what works in health care. The vast majority of physicians are eager to get such information and to act on it.

We are not sure what HCFA's role in this area should be... But we are sure that HCFA must play a role.

I believe we will always devote a large share of our economy to health care. However, what I think is growing is a demand for value in health spending. Value in the sense of paying for procedures and activities that are effective, and value in the sense of investing incremental dollars in ways that have the most return.

This is why I said at the outset that the concept of value was a useful way to interweave the demands of cost constraint, competition and quality in health care.

Surely there are limits to our resources. One of the uncomfortable realities, now dawning in the late 1980s, is that our aspirations have outstripped our resources. Therefore we must do a much better job of targeting our health care spending.

This will necessitate hard choices -- by people of good will. As I have said earlier, I believe decentralized decisions of this sort are likely to prove better than centralized ones.

We must resist telling ourselves that the old ways were the best ways, and commit ourselves to the enterprise ahead.

I believe the policy I have described is one of vision, but a vision tempered by pragmatism. I believe that a more competitive system of private providers and aware consumers will ensure a bright future for health care in America, at a price we all can afford.

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